

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04510

Item 1. Film 628 4/28/58 fcy

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mason Springs</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>RICHARD C. ASHTON</u>		4. DATE OF DEATH Month <u>4</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 9, 1931</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ripley, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Ashton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mabel Bowman, Pisgah, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage into placental</u> DUE TO (b) <u>2 bullet wounds of</u> DUE TO (c) <u>Chest</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot by assailant</u>	
20c. TIME OF INJURY Month, Day, Year <u>4-20-58</u> Hour a. m. <u>1</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Mason Springs, Charles Co., Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. E. E. E. E. E.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. E. E. E. E. E.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 23, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Smith Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Pisgah Charles Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson and Jenkins</u>		24a. REC'D BY REGISTRAR <u>APR 24 '58</u>	
ADDRESS <u>4804 Georgia Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Couch</u>	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH
4-20-58

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

DATE SIGNED

4-20-58

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. Includes checkboxes for various conditions and a large area for narrative notes.

BUREAU V. S.

APR 24 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4521 CERTIFICATE OF DEATH

04511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lepidala</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Point</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Phy Mem Hosp</u>				d. STREET ADDRESS <u>Rock Point</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Evay</u> Middle <u>Barbour</u> Last <u>Barbour</u>				4. DATE OF DEATH <u>4</u> Month <u>18</u> Day <u>1958</u> Year			
5. SEX <u>17</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-11-85</u>	
9. AGE (In years less birthday) <u>73</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Master</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Charles Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Thomas Barbour</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lucilla Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Robert T Barbour</u>			
17. INFORMANT <u>Robert T Barbour</u>				Address <u>Port Tobacco Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>449x Congestive Heart Failure</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-1-58</u> <u>1956</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>4-17-58</u> , to <u>4-18-58</u> , that I last saw the deceased alive on <u>4-17-58</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. J. Edelen</u> M.D.				DATE SIGNED <u>4-18-58</u>			
PHYSICIAN'S NAME (Type) <u>R. J. EDELEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>		22b. DATE THEREOF <u>4/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Rest</u>		22d. LOCATION (City, town, or county) <u>Lepidala</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Lepidala</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u>APR 23 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4522 Items 7-9 Film G228 5-9-58 et

04512

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laplate				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Marlbury md			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicum Memorial Hosp				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Juanita First Middle BURGESS Last				4. DATE OF DEATH APRIL 17 Month Day Year 1958			
5. SEX Female	6. COLOR OR RACE CS-W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Approx.		9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) virginia		12. CITIZEN OF WHAT COUNTRY? usa	
13. FATHER'S NAME Thombery				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Josie Shell Marlbury md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Cardio-vascular failure DUE TO (b) CUA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Glomerular arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 11 days. year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6 Apr , 1958, to 17 Apr , 1958, that I last saw the deceased alive on 17 Apr , 1958, and that death occurred at 3:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur G. Woody M.D.				ADDRESS (Street, city or town, state) La Plata Md. DATE SIGNED 18 April 58			
PHYSICIAN'S NAME (Type) ARTHUR G. WOODY							
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		22b. DATE THEREOF 4-20-58		22c. NAME OF CEMETERY OR CREMATORY Park Hill		22d. LOCATION (City, town, or county) (State) Marlbury Charles co md.	
23. FUNERAL DIRECTOR'S SIGNATURE Grethart Inc Laplate Md. ADDRESS				24a. REC'D BY REGISTRAR DATE APR 24 '58		24b. REGISTRAR'S SIGNATURE W. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

1. NAME OF DECEASED: *John Doe*

2. DATE OF DEATH: *10/15/1918*

3. PLACE OF DEATH: *Home*

4. CAUSE OF DEATH: *Pneumonia*

5. PLACE OF BIRTH: *MD*

6. DATE OF BIRTH: *10/15/1880*

7. SEX: *Male*

8. OCCUPATION: *Farmer*

9. MARITAL STATUS: *Married*

10. NAME OF SPOUSE: *Jane Doe*

11. NAME OF PHYSICIAN: *Dr. J. Smith*

12. NAME OF BURIAL PLACE: *St. Mary's Cemetery*

13. NAME OF MINISTER: *Rev. J. Brown*

14. NAME OF WITNESSES: *John Doe, Jane Doe*

15. NAME OF REGISTRAR: *John Doe*

16. NAME OF CLERK: *John Doe*

17. NAME OF DEPUTY CLERK: *John Doe*

18. NAME OF ASSISTANT CLERK: *John Doe*

19. NAME OF CLERK: *John Doe*

20. NAME OF CLERK: *John Doe*

BUREAU V. S.

RECEIVED

APP

4523

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARBURY</u>				c. LENGTH OF STAY IN 1b <u>45 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOME : MARBURY, MD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LLEWELLYN</u> First <u>GILLMORE</u> Middle <u>DOANE</u> Last				4. DATE OF DEATH <u>APRIL</u> Month <u>2ND</u> Day <u>1958</u> Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 19th 1878</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED GROCERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HAMPDEN, MAINE</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>ISAAC DOANE</u>				14. MOTHER'S MAIDEN NAME <u>Laura COLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-32-9894</u>		17. INFORMANT <u>MRS. NELLIE DOANE, MARBURY, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY INSUFFICIENCY</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL THROMBOSIS</u> DUE TO <u>GENERAL ARTERIOSCLEROSIS</u> (c) <u>HEMIPLEGIA, RIGHT</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HEMIPLEGIA, RIGHT</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u> <u>JAN 26, 1958</u> <u>YEARS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>APRIL 10, 1956</u> , to <u>APRIL 2ND, 1958</u> , that I last saw the deceased alive on <u>APRIL 2ND, 1958</u> , and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>ACCOKEEN, MD.</u> DATE SIGNED <u>APRIL 2ND, 1958</u> ACTUAL SIGNATURE <u>Paul Chen</u> M.D. PHYSICIAN'S NAME (Type) <u>PAUL CHEN, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Marbury Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Marbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u> ADDRESS <u>Waldorf, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Albion</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

4223

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		JAN 15 1888		BALTIMORE		MD		MD		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
LABORER		8 YEARS		MARRIED		METHODIST		WHITE		WHITE		5 FT 10 IN		170 LB	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
APR 1 1958		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST		NO		NO	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF JUDGE	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APR 1 1958		APR 1 1958		APR 1 1958		APR 1 1958		APR 1 1958		APR 1 1958		APR 1 1958		APR 1 1958	

BUREAU V. 3
APR 7 1958

RECEIVED

4/1/58 Maryland Department of Health
Baltimore, Md.

Items 18-21 Film 332 8-11-58

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle VICTORIA Last FARMER		4. DATE OF DEATH Month April Day 7 Year 19 58	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1913
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Nicholas Campbell		14. MOTHER'S MAIDEN NAME Frances Chesley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Joseph Farmer, La Plata, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Manual Strangulation 983X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 983X DUE TO cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Manual strangulation	
20c. TIME OF INJURY Month, Day, Year Hour o. m. Found 4/7/58 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Field		20f. (City or town) (County) (State) La Plata Charles Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/7/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 4/10/58	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) La Plata, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home, Waldorf, Md		ADDRESS	
24a. REC'D BY REGISTRAR APR 11 '58		24b. REGISTRAR'S SIGNATURE Quelovich	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
HEALTH DEPT.



NAME OF DECEASED
AGE
SEX
RACE
DATE OF DEATH
PLACE OF DEATH
CITY
COUNTY
STATE

CAUSE OF DEATH
MANNER OF DEATH
PLACE OF INTERMENT
DATE OF INTERMENT
NAME OF FUNERAL HOME
NAME OF MINISTER OF THE GOSPEL
NAME OF CLERGYMAN

NAME OF PHYSICIAN
NAME OF SURGEON
NAME OF DENTIST
NAME OF MIDWIFE
NAME OF NURSE
NAME OF ATTENDING CLERGYMAN

NAME OF WITNESSES
NAME OF JURY
NAME OF JUDGE
NAME OF CLERK
NAME OF SHERIFF
NAME OF DEPUTY SHERIFF

NAME OF REGISTRAR
NAME OF CLERK
NAME OF SHERIFF
NAME OF DEPUTY SHERIFF
NAME OF JURY
NAME OF JUDGE
NAME OF CLERK
NAME OF SHERIFF
NAME OF DEPUTY SHERIFF

RECEIVED
APR 11 1958
BUREAU V. S.

4525 Item 9 11-11-58 et
CERTIFICATE OF DEATH

04515

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pomfret c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pomfret d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle ANGIE Last Harley		4. DATE OF DEATH Month 11 Day 23 Year 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 25, 1886 7/12/86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME AL Thompson		14. MOTHER'S MAIDEN NAME Elizabeth Swann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Louise H. Butler, La Plata, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Longestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Myocardial Infarction DUE TO (c) Hypertensive Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH 1 wks. 1 wks. years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11 19 57 to 11-22 19 58 that I last saw the deceased alive on 4-22 19 58 , and that death occurred at 5:17 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata, Maryland DATE SIGNED 4-23-58			
ACTUAL SIGNATURE E. J. Edelen		M.D. E. J. Edelen, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/58	
22c. NAME OF CEMETERY OR CREMATORY St Josephs		22d. LOCATION (City, town, or county) (State) Pomfret, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR 4-29-58 24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		65		M		W		JAN 15 1893		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1000 N. E. ST.		LABORER		HEART DISEASE		NATURAL		APR 15 1958		BALTIMORE, MD.	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
JAMES H. HARRIS		MARY J. HARRIS		8		METHODIST		MARRIED		MARRIED	
DATE OF MARRIAGE		DATE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		DATE OF INTERMENT		PLACE OF INTERMENT	
JAN 15 1915		APR 15 1958		APR 15 1958		BALTIMORE, MD.		APR 15 1958		BALTIMORE, MD.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF FUNERAL HOME	
JAMES H. HARRIS		MARY J. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU Y. 3

APR 29 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04516

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> <u>4526</u> <u>Laplace Md</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Mass.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laplace</u>		c. LENGTH OF STAY IN 1b <u>58x-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Attleboro</u>	
3. NAME OF DECEASED (Type or print) First <u>FRIED A</u> Middle <u>HOLTER</u> Last <u>HOLTER</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>11</u> Year <u>1968</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1884</u>
9. AGE (in years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Berlin Germany</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benikowski</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>0</u>	
17. INFORMANT <u>Annie Jaeger Providence Ri</u>		Address <u>Providence Ri</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u> <u>816X</u> DUE TO <u>BILATERAL FRACTURES OF FEMURS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>AND SCALP LACERATIONS</u> DUE TO <u>AND SCALP LACERATIONS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>0</u> <u>1 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>HIGHWAY AUTO ACCIDENT - HEAD ON COLLISION</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7:05</u> <u>PM</u> <u>4-11</u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HIGHWAY</u>		20f. (City or town) (County) (State) <u>LA PLATA, CHARLES MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>V. B. Detton</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V. B. DETTON</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11 April 1958</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-14-58</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archard Inc Laplace Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 15 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Archard</u>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

APR 15 1938

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4527

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Mass</u> b. COUNTY <u>Attleboro</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leplata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Attleboro</u> 581-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Phy Mem Hosp</u>		d. STREET ADDRESS <u>581-3</u>	
3. NAME OF DECEASED (Type or print) First <u>OSCAR</u> Middle <u>HOLTER</u> Last <u>HOLTER</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 28, 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Silver Smith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Old Norway</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>02-01-9764</u>	
17. INFORMANT <u>Connie Jaegle Providence RI</u>		Address <u>Providence RI</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Fractures, both legs</u> (c) <u>and Crush Injuries of Chest</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 15 min.</u> <u>1 hr. 15 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Auto Accident - U.S. 301 - Head on collision</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>4-11 1958</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HIGHWAY</u>		20f. (City or town) (County) (State) <u>LA PLATA, CHARLES, MD.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>V. B. Dettora</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V. B. DETTORA</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-14-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		22d. LOCATION (City, town, or county) (State) <u>Providence RI</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherhart Inc Leplata Md</u>		ADDRESS <u>Leplata Md</u>	
24a. REC'D BY REGISTRAR <u>APR 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Attleboro</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

RECEIVED

4528

CERTIFICATE OF DEATH

04518

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>CHARLES</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>CHARLES</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LAPLATA</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X BEL ALTON</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Phys. Mem. Hospital</i>			d. STREET ADDRESS <i>1</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <i>Infant</i> Middle <i>JENKINS</i> Last <i>JENKINS</i>			4. DATE OF DEATH Month <i>Apr</i> Day <i>12</i> Year <i>1958</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-11-78</i>	9. AGE (In years last birthday) yrs. <i>1</i>	IF UNDER 1 YEAR Months <i>1</i> Days <i>1</i> Hours <i>1</i> Min. <i>1</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>INFANT</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>LOUIS SIDNEY MASON</i>			14. MOTHER'S MAIDEN NAME <i>Cecelia Alice Jenkins</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Alice Jenkins, BEL ALTON MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory collapse</i> <i>762.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>prematurity</i> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>1 day</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <i>4-11</i> , 19 <i>58</i> , to <i>4-12</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>4-12</i> , 19 <i>58</i> , and that death occurred at <i>11:30 PM</i> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>F. M. Johnson</i> M.D.			ADDRESS (Street, city or town, state) <i>La Plata Md</i> DATE SIGNED <i>4-13-58</i>		
PHYSICIAN'S NAME (Type) <i>F. M. Johnson, M.D.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>4/15/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Thomas Farm</i>	22d. LOCATION (City, town, or county) <i>La Plata Md</i> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard M. La Plata</i> ADDRESS <i>La Plata Md</i>			24a. REC'D BY REGISTRAR DATE <i>APR 18 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Richard M. La Plata</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2066232XVI

8361 31 234

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04519

4529

Reg. Dist. No.

FOR STATE
HEALTH DEPT.1. PLACE OF DEATH
a. COUNTY

Charles

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Char 105

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural - La Plata

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

x Hughesville

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?YES ☒ NO ☐3. NAME OF
DECEASED
(Type or print)

RALPH

First

Middle

S. JOHNSON

Last

4. DATE
OF DEATH

Month

Day

Year

4

18

1958

5. SEX

M

6. COLOR OR RACE

7. MARRIED-☒ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

WIDOWED ☐ DIVORCED ☐

JAN 4 1927

31

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Govt.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Roy Johnson

14. MOTHER'S MAIDEN NAME

SARA S. JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

219-16-0287

17. INFORMANT

Address

Victorini Johnson, Hughesville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

816x

DUE TO

Cerebral Hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

4-18-58

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

Brain. Stroke

4-18-58

(c)

Auto accident

4-18-58

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Two car collision

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. City or town

(County)

(State)

Hour

p. m.

4-18-58

While
at work ☐ Not while
at work ☒20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Hughesville

20f. City or town

Bryantown, Md.

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

E. J. EDELEN

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S
NAME (Type)

E. J. EDELEN

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

4-19-58

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

Burial

4-22-58

ST MARYS CEM.

Bryantown Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Heath Funeral Home

Wesley, Md.

DATE APR 23 '58

Deledon

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
DEPARTMENT



Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU K. H.

APR 23 1938

RECEIVED

4530

CERTIFICATE OF DEATH

Reg. Dist. No.

04520

1. PLACE OF DEATH o. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>				c. LENGTH OF STAY IN 1b <u>x</u> <u>MT Victoria</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physician Memorial</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>C.</u> Last <u>KEYE JR.</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 29, 1925</u>		9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COMMERCIAL</u>		11. BIRTHPLACE (State or foreign country) <u>WASH., D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WALTER C. KEYE, SR</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Ford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>215 26 3636</u>		17. INFORMANT <u>Dorothy KEYE</u> Address <u>MT Victoria, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>diabetic acidosis</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 2</u> , 19 <u>58</u> , to <u>Apr 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Apr 2</u> , 19 <u>58</u> , and that death occurred at <u>3:00 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. M. JOHNSON</u> M.D.		ADDRESS (Street, city or town, state) <u>La Plata, Md.</u> DATE SIGNED <u>4-5-58</u>					
PHYSICIAN'S NAME (Type) <u>F. M. JOHNSON M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-8-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shiloh MET. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Newburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HUNT FUNERAL HOME</u>				ADDRESS <u>WALCOTT, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Overman</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938



NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARITAL STATUS		OCCUPATION		EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		COUNTY		TOWNSHIP	
NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARITAL STATUS		OCCUPATION		EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		COUNTY		TOWNSHIP	

BUREAU V. S.

APR 9 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04521**

FOR STATE
HEALTH DEPT.

4531

1. PLACE OF DEATH a. COUNTY <i>Charles</i> <i>md.</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Newport</i> b. COUNTY <i>Charles</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laplate md.</i>			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Phy mem</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>JOHN</i> First <i>LOUIS</i> Middle <i>KNOTT</i> Last			4. DATE OF DEATH <i>APRIL</i> Month <i>1</i> Day <i>1958</i> Year		
5. SEX <i>male</i>	6. COLOR OR RACE <i>col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 16 1911</i>		9. AGE (in years last birthday) <i>46</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>		11. BIRTHPLACE (State or foreign country) <i>Charles Co</i>	12. CITIZEN OF WHAT COUNTRY? <i>W.S.A.</i>
13. FATHER'S NAME <i>Ferwick Knott</i>			14. MOTHER'S MAIDEN NAME <i>Mary Carter</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>John W. Knott Newport md</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Insufficiency</i> <i>581.1</i> DUE TO (b) <i>Cirrhosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Alcoholism</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>1 year</i> <i>years</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Death</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>no injury</i>			
20c. TIME OF DEATH Month, Day, Year <i>4-1-1958</i> Hour a. m. <i>4:15</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>V. B. Detton</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>1 April 1958</i>	
EXAMINER'S NAME (Type) <i>V. B. DETTOR</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-4-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St Marys</i>	
22d. LOCATION (City, town, or county) <i>Newport md.</i>		22e. (State)		23. FUNERAL DIRECTOR'S SIGNATURE <i>Grehan Inc Laplate md.</i> ADDRESS	
24a. REC'D BY REGISTRAR <i>APR 8 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. S. ...</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH USE

11

1931

MARYLAND STATE DEPARTMENT OF
MUNICIPAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 8 1933

RECEIVED

4532

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rural.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS W. LYON				4. DATE OF DEATH Month Day Year APRIL 30 1958			
5. SEX Male		6. COLOR OR RACE W-		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 25, 1869	
9. AGE (In years lost birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James T. Lyon				14. MOTHER'S MAIDEN NAME Rebecca Lyon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-38-2726		17. INFORMANT Address Harold Lyon, La Plata, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Collapse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart failure. DUE TO (c) Artero-sclerotic-cardio-renal disease						INTERVAL BETWEEN ONSET AND DEATH 20 min 2 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 19, 1948 to 30 May 1958 , that I last saw the deceased alive on 30 May 1958 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur O. Woody M.D.				DATE SIGNED 30 April 58			
PHYSICIAN'S NAME (Type) ARTHUR O. WOODY				ADDRESS Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/2/58		22c. NAME OF CEMETERY OR CREMATORY Mt Rest		22d. LOCATION (City, town, or county) (State) La Plata, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The Huatt Funeral Home, Waldorf, Md.				24a. REC'D BY REGISTRAR DATE MAY 5 '58		24b. REGISTRAR'S SIGNATURE Reed Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM BROWN

NAME OF DECEASED		WILLIAM BROWN	
AGE		45	
SEX		Male	
RACE		White	
DATE OF DEATH		JAN 15 1945	
PLACE OF DEATH		Home	
CAUSE OF DEATH		Heart Disease	
MANNER OF DEATH		Natural	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF WITNESS		[Signature]	
SIGNATURE OF DECEASED		[Signature]	
SIGNATURE OF NEXT OF KIN		[Signature]	
SIGNATURE OF BURIAL OFFICIAL		[Signature]	
SIGNATURE OF REGISTRAR		[Signature]	
SIGNATURE OF CLERK		[Signature]	
SIGNATURE OF JUDGE		[Signature]	
SIGNATURE OF SHERIFF		[Signature]	
SIGNATURE OF DISTRICT ATTORNEY		[Signature]	
SIGNATURE OF COUNTY CLERK		[Signature]	
SIGNATURE OF CITY CLERK		[Signature]	
SIGNATURE OF VICE MAYOR		[Signature]	
SIGNATURE OF MAYOR		[Signature]	

4533

04523

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charles</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Had</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>M.</u> Last <u>ROSS</u>		4. DATE OF DEATH Month <u>4</u> - Day <u>19</u> - Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-20-1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant - Naval Powder Factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Attendant - Naval Powder Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Charles</u>		12. CITIZEN OF WHAT COUNTRY? <u>Charles</u>	
13. FATHER'S NAME <u>Arthur M. Ross</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u></u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>ONE MO.</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 11, 1957</u> , to <u>APRIL 20, 1958</u> , that I last saw the deceased alive on <u>APRIL 20, 1958</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Chen</u> M.D.		ADDRESS (Street, city or town, state) <u>ACCOKEEK</u> DATE SIGNED <u>APRIL 20, 1958</u>	
PHYSICIAN'S NAME (Type) <u>PAUL CHEN M.D.</u>		<u>MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>April 23, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Rest</u>	22d. LOCATION (City, town, or county) (State) <u>La Plata, Charles, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson and Jenkins</u> ADDRESS <u>4804 Georgia Ave. N.W.</u>		24a. REC'D BY REGISTRAR <u>APR 24 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Form 100

Charles

Myers

Robert H. H. H.

John

28

4-19

6-22-1872

White Church

Charles

Myers

Arthur M. Brown

BUREAU V. 2

APR 2 1902

RECEIVED

4534

CERTIFICATE OF DEATH

04524

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANN</u> Middle <u>WALKER</u> Last <u>WALKER</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-29-58</u>
9. AGE (In years last birthday) yrs. <u>11</u> Months <u>11</u> Days <u>33</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>THOMAS JEFFERSON WALKER</u>		14. MOTHER'S MAIDEN NAME <u>ESTELLA ELIZABETH HUNT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. ADDRESS <u>T.J. WALKER, LA PLATA, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY - INADEQUACY OF</u> <u>774X</u> DUE TO <u>CENTRAL NERVOUS DEVELOPMENT -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>EXPECTED DATE OF DELIVERY (7-20-58)</u> DUE TO (c) <u>RESPIRATORY FAILURE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>11 hr. 37 min</u> <u>4 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> p. m. <u>—</u> 19 <u>58</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that I attended the deceased from <u>4/29/58</u> , 19 <u>58</u> , to <u>4/30</u> , 19 <u>58</u> , that I lost the deceased alive on <u>4/30</u> , 19 <u>58</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Griffin</u> M.D.		EST ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u> DATE SIGNED <u>4/30/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-1-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Peters</u>	22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf, Md.</u> ADDRESS <u>2166 283XV2</u>		24a. REG. BY REGISTRAR <u>MAY 5 1958</u> DATE	24b. REGISTRAR'S SIGNATURE <u>—</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4535 CERTIFICATE OF DEATH

04525

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PHILIP</u> Middle <u>WALKER</u> Last <u>WALKER</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>29</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 29, 1958</u>
9. AGE (In years last birthday) <u>1</u> yrs. <u>1</u> month <u>57</u> days		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>THOMAS JEFFERSON WALKER</u>		14. MOTHER'S MAIDEN NAME <u>ESTELLA ELIZABETH HUNT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>T.J. WALKER</u>		Address <u>LA PLATA, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>774X</u> <u>PREMATURITY - INADEQUACY OF CENTRAL NERVOUS DEVELOPMENT - EXPECTED DATE OF DELIVERY (7-20-58)</u> DUE TO (b) <u>RESPIRATORY FAILURE</u> DUE TO (c) <u>—</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 57 min.</u> <u>30 min.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>4/29</u> , 19 <u>58</u> , to <u>4/29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/29</u> , 19 <u>58</u> , and that death occurred at <u>10:35 PM</u> , from the causes and on the date stated above. EST ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>4/30/58</u>			
ACTUAL SIGNATURE <u>John H. Guffin</u> M.D.		PHYSICIAN'S NAME (Type) <u>—</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-1-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Peters</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 5 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		24c. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2266284XV2

U.S.A. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF VITAL RECORDS
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20540

DEATH CERTIFICATE

MALE

6522 CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH & HUMAN SERVICES

NAME (Last, first, middle initial) WILLIAM BOMM	
DATE OF BIRTH 1914	PLACE OF BIRTH NEW YORK
DATE OF DEATH 1978	PLACE OF DEATH NEW YORK
CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL	
SIGNATURE OF REGISTRAR [Signature]	
DATE OF REGISTRATION 1978	
OFFICE OF VITAL RECORDS NEW YORK	